

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

01758

Reg. Dist. No. 2040 402

## 1. PLACE OF DEATH

County West  
City or town near Fairlee  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 27 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County West  
City or town Fairlee  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Chesapeake R.R. Rd  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

Clarence Albert Ackerman

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mollie Ferguson  
7. Birth date of deceased (mo., day, yr.) October 10th 1876 8.(c) If alive, give age 69 years

8. AGE: Years 70 Months 4 Days 5 If less than one day  
.....hrs. ....min.

9. Birthplace Berlin Springs, Michigan  
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name James Rainer Ackerman

13. Birthplace Berlin, Pa.

14. Maiden name Nancy Baker

15. Birthplace Berlin Springs, Michigan

16. Informant Mrs. Mollie Ackerman wife

Address Chesapeake R.R. Rd

17. Burial Date thereof 2/20/47  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Ches.

Location Chesapeake, Maryland

18. Funeral director Marion V. Williams

Address Chesapeake, Maryland

19. Feb 19 1947 F. W. Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH February 15 1947, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 1947, to Feb 14 1947

and that I last saw him alive on Feb. 14 1947

Immediate cause of death Sepsis DURATION 10 days

Due to Infection of Left Leg

Due to Fracture of Leg

Other conditions Fracture of Leg, Feb 5, 47.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank D. Smith M. D. or other

Address Chesapeake Date signed 2/15/47

CERTIFICATE OF DEATH

RECEIVED

FEB 21 1947

BUREAU V & A

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

01759

Reg. Dist. No. 2020

## 1. PLACE OF DEATH:

County Kent  
 City or town Chestertown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all life  
 Hospital, institution, or street address where death occurred:  
142 Prospect St.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Kent  
 City or town Chestertown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 142 Prospect  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Martha Burgess

## 3. (b) Social Security Number

4. Sex F 5. Color or race C. 6. (a) Single, married, widowed, or divorced Widowed  
 8. (b) Name of husband or wife (late) John Burgess  
 7. Birth date of deceased (mo., day, yr.) April 7 1891 8. (c) If alive, give age — years  
 8. AGE: Years 55 Months 10 Days 16 If less than one day — hrs. — min.

9. Birthplace Near - Chestertown Kent Co. Md.  
(Town, county, and state)10. Usual occupation housewife11. Industry or business houseFATHER 12. Name Unknown13. Birthplace —MOTHER 14. Maiden name Unknown15. Birthplace —16. Informant Victoria White (daughter)Address 142 Prospect St. Chestertown Md17. Burial Date thereof 2/25/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ChestertownLocation Near Chestertown Maryland18. Funeral director Marvin V. WilliamsAddress Chestertown, Maryland19. Feb. 25 19 47 Clara L. Barnes  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 19 47 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-19 19 47 to 2-23 19 47  
 and that I last saw her alive on 2-23- 19 47

Immediate cause of death intracranial hemorrhage DURATION 6 days  
 Due to arterial hypertension

Due to —  
 Other conditions —

(Include pregnancy within 8 months of death)  
 Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Clara L. Barnes M. D. or other —Address Chestertown, Md Date signed 2-24-47

STATEMENT OF INVESTIGATION

U.S. DEPARTMENT OF JUSTICE

STATE OF NEW YORK

IN SENATE

1947

STATE OF NEW YORK

RECEIVED

FEB 27 1947

BUREAU V B

1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2030

## 1. PLACE OF DEATH:

County Kent  
 City or town Rock Hall Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 years  
 Hospital, institution, or street address where death occurred:  
Haven  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Kent  
 City or town Rock Hall Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Haven  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Henriette Chandler

## 3. (b) Social Security Number

4. Sex female 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Jacob Chandler  
 7. Birth date of deceased (mo., day, yr.) Jan 9 1881  
 8. AGE: Years 66 Months 1 Days 18 If less than one day  
 6. (c) If alive, give age 72 years

9. Birthplace Hammer, Germany  
 (Town, county, and state)  
 10. Usual occupation housework  
 11. Industry or business own house  
 12. Name Paul von Bringer  
 13. Birthplace Germany  
 14. Maiden name Helene Yench  
 15. Birthplace Germany

16. Informant Jacob Chandler  
 Address Rock Hall, Md.  
 17. Burial Date thereof 3/2/47  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Wesley Chapel  
 Location Rock Hall Md.  
 18. Funeral director Edgar L. Lane  
 Address Church Hill Md.  
 19. 2/28 1947 S. Elwood Bingen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1947 at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 6 1947 to Feb 27 1947  
 and that I last saw him alive on Feb 20 1947

Immediate cause of death acute cardiac failureDue to chronic sub-inguarthritisDue to hypertensionOther conditions gallbladder disease

(Include pregnancy within 8 months of death)

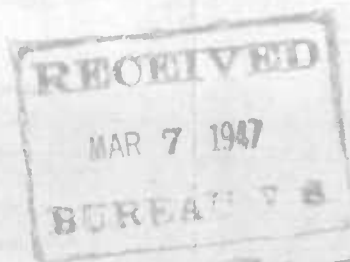
Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE Albert A. Buegard M. D. or other.....  
Rock Hall, Md. Date signed 2/28/47  
 Address.....



2-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01761

Reg. Dist. No. 2020

## 1. PLACE OF DEATH:

County Keokuk  
 City or town Chesapeake  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1/29/47  
 Hospital, institution, or street address where death occurred:  
Keokuk and Chesapeake General Hosp.  
 How long in hospital or institution? 3 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Keokuk  
 City or town Rock Hall Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Piney Neck  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

George Edward Cason

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

SINGLE

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

Jan 29 1947

## 6. (c) If alive, give age

## 8. AGE:

Years

Months

Days

If less than one day

--3

hrs.

min.

## 8. Birthplace

Chesapeake, Md  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

William Otto Cason

## 13. Birthplace

Baltimore, Md

## MOTHER

## 14. Maiden name

M. Pauline Wilhelm

## 15. Birthplace

Baltimore, Md.

## 16. Informant

Wm O Cason

## Address

Rock Hall, Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Feb 3 1947  
(month) (day) (year)

## Cemetery or crematory

Wesley Chapel

## Location

near Rock Hall, Md

## 18. Funeral director

Willis Wells

## Address

Chesapeake, Md

## 19.

Feb. 2, 1947  
(Date rec'd by registrar)Clara S. Barnes  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1947, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/29 1947, to 2/1 1947and that I last saw him alive on 1/31 1947

## Immediate cause of death

intracranial hemorrhage

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Robert A Burgard

M. D. or other

## Address

Rock Hall, MdDate signed 2/1/47

RECEIVED TO THE ATTORNEY GENERAL

RECEIVED TO THE ATTORNEY GENERAL

RECEIVED  
FEB 4 1947  
BUREAU

1-35



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

01762

## 1. PLACE OF DEATH

County Kent Registration Dist. No. 2060  
 Village or City Worton Md. Colemans No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME

Elizabeth Marie Halsey If U. S. Veteran, specify WAR \_\_\_\_\_  
 (a) Residence: No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) If nonresident give city or town and State \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6. DATE OF BIRTH (month, day, and year) Dec 8 1946

7. AGE Years \_\_\_\_\_ Months 2 Days 10 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month end year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (city or town) Worton Md. Colemans  
 (State or country) Maryland

13. NAME Aldridge Halsey  
 14. BIRTHPLACE (city or town) Colemans Worton Md.  
 (State or country) Maryland

15. MAIDEN NAME Irene Graves  
 16. BIRTHPLACE (city or town) Colemans Worton Md.  
 (State or country) Maryland

17. INFORMANT Aldridge Halsey  
 (Address) Worton Md. Colemans

18. BURIAL, CREMATION, OR REMOVAL  
 Place Colemans Date Feb 19, 1946

19. UNDERTAKER B. R. Wellons  
 (Address) Still Pond Md.

20. FILED Feb 19, 1947 J. William Clark  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Feb 18, 1947  
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1947, to Feb 17, 1947

I last saw her alive on Feb 17, 1947; death is said to have occurred on the date stated above, at 5 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Intestinal Colic Date of onset \_\_\_\_\_

Other Contributory Causes of Importance:

acute cold

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (Specify city or town, county and State)  
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) L. P. Atwell M. D.  
 (Address) Still Pond Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

## Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

BUREAU V B

2-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 2010

01764

## 1. PLACE OF DEATH:

County KentCity or town Still Pond  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 years

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Still Pond md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(d) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Leda Francis Jones

## 3. (b) Social Security Number

218-16-9111

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Harry Jones

7. Birth date of

deceased (mo., day, yr.)

Apr 21 18806. (c) If alive, give age 69 years

8. AGE:

Years

Months

Days

If less than one day

66106

hrs.

min.

9. Birthplace

Rock Hall  
(Town, county, and state)

10. Usual occupation

Vital Food Co

11. Industry or business

FATHER

12. Name

Richard Webb

13. Birthplace

Maryland

MOTHER

14. Maiden name

Rachel Simmons

15. Birthplace

Maryland

16. Informant

Harry Jones

Address

Still Pond md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 2 1947  
(month) (day) (year)

Cemetery or crematory

Still Pond md

Location

Still Pond md

18. Funeral director

W. B. Bellows

Address

Still Pond md

19.

(Date rec'd by registrar)

3/2 47J. Mearns

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1947, at 11:57 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 27 to 47 to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Endocarditis  
unknown

Due to

Due to

Other conditions acute indigestion

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. P. Atwell

M. D. or other

Address

Still PondDate signed 2-28-47

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

RECEIVED  
MAR 5 1947  
BUREAU 8.

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

01763

## 1. PLACE OF DEATH

County Kent  
 City or town Piney Neck  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Kent  
 City or town Piney Neck  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Piney Neck  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

William F. Harold Kendall

## 3. (b) Social Security Number

213-14-1569

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 10 - 1896 8. (c) If alive, give age..... years

8. AGE: Years 50 Months 4 Days 9 If less than one day..... hrs. .... min.

9. Birthplace Piney Neck Kent Co  
 (Town, county, and state)

10. Usual occupation Waterman

## 11. Industry or business

12. Name William F. Kendall

13. Birthplace Kent Co

14. Maiden name Mary Malinda Bluetstein

15. Birthplace Kent Co

16. Informant Mary Elizabeth White

Address Piney Neck Md

17. Burial Date thereof 2-23-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Winters Chapel

Location Piney Neck Md

18. Funeral director Edgar J. Lane

Address Church Hill Md

19. 2/23 47 S. Elwood Binger  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 19 47 at 60 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46 to Jan 19 47

and that I last saw him alive on Jan 19 47

Immediate cause of death sudden

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other conditions Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Heart Attack

23. SIGNATURE Frances W. Smith

M. D. or other

Address Chesapeake Date signed 2/24/47



RECEIVED  
FEB 25 1947  
BUREAU

4-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 01765 2030

## 1. PLACE OF DEATH:

County Kent  
 City or town Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all life  
 Hospital, institution, or street address where death occurred:  
Rock Hall  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent  
 City or town Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Mary Coleman Munch

## 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Harry D. Munch  
 7. Birth date of deceased (mo., day, yr.) March 16 1903  
 6.(c) If alive, give age 47 years  
 8. AGE: Years 43 Months 11 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rock Hall, Maryland  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

12. Name Marion Coleman

13. Birthplace Rock Hall

14. Maiden name Ella Taylor

15. Birthplace Worton, Kent Co., Md.

16. Informant Mr. Harry D. Munch

Address Rock Hall, Maryland

17. Burial Date thereof 2 26 47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wesley Chapel

Location Rock Hall, Md.

18. Funeral director Marion V. Williams

Address Chattanooga, Maryland

19. 2/25 19 47 S. Elwood Binger  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 19 47 at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 19 47 to Feb 23 19 47 and that I last saw him alive on Jan 31 19 47

Immediate cause of death acute cardiac failure  
chronic pulmonary hypertension

Due to hypertension

Due to Pregnancy (6 mo.)

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Reberta Burgard M. D. or other \_\_\_\_\_

Address Rock Hall, Md. Date signed 2/24/47

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 27 1947

BUREAU V 8

1-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# Evidence for the change of MARYLAND STATE DEPARTMENT OF HEALTH

age is shown on

G 108 2/10/47

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01766

Reg. Dist. No. 2030

### 1. PLACE OF DEATH:

County Rock HallCity or town Rock Hall  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all lifeHospital, institution, or street address where death occurred: noHow long in hospital or institution? no

### 3. (a) FULL NAME

Benjamin Swell

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Mary Catherine Proctor7. Birth date of deceased (mo., day, yr.) Jan 18, 1863 6. (c) If alive, give age 84 years8. AGE: Years 84 Months 7 Days 11 If less than one day hrs. min.9. Birthplace Rock Hall Kent Co Md  
(Town, county, and state)10. Usual occupation waterman11. Industry or business coachman12. Name Thomas Samuel Swell13. Birthplace Garra Anne Sound14. Maiden name Mary Jane Deacon15. Birthplace Rock Hall Kent Co Md16. Informant Benjamin SwellAddress Rock Hall Md17. Buried Date thereof Feb 4, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wesley ChapelLocation Rock Hall Md18. Funeral director Edgar R. LaneAddress 6 Birch Hill Md19. Feb 3 19 47 S. Elwood Bowers  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Rock HallCity or town Rock Hall  
(If outside city or town limits, write RURAL and give nearest town)Street No. no  
(If rural, give LOCATION)2. (a) If veteran, name war no

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4, 1947 at 8 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to 1947 and that I last saw him alive on Feb 4, 1947Immediate cause of death arteriosclerosis DURATION arteriosclerosisDue to arteriosclerosisDue to arteriosclerosisOther conditions no

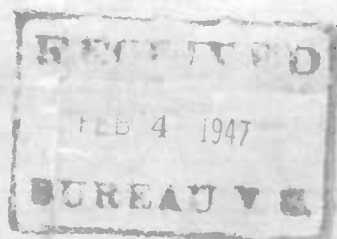
(Include pregnancy within 3 months of death)

Major findings of operations noDate of op. noAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of noWhere did injury occur? no  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) noMeans of injury no Injured at work? no23. SIGNATURE Benjamin Swell M. D. or other noAddress Rock Hall Md Date signed Feb 4, 1947



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2030

## 1. PLACE OF DEATH:

County KentCity or town Chestertown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Emma Louise Shirley4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Jacob Shirley7. Birth date of deceased (mo., day, yr.) February 1st, 18558. AGE: Years 93 Months 0 Days 11 If less than one day9. Birthplace Wesley Chapel, Kent Co.  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name James Lamb13. Birthplace Kent Co. Md.14. Maiden name Anna Elizabeth Bates15. Birthplace Kent Co. Md.16. Informant Mrs. Walter GudrunAddress Chestertown Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 15, 1947  
(month) (day) (year)Cemetery or crematory Wesley Chapel Cem.Location Near - Rock Hall, Maryland18. Funeral director J. Willis WellsAddress Chestertown, Maryland19. Feb. 14, 1947 Clara S. Barnes  
(Date rec'd by Registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County KentCity or town Wesley Chapel, Kent Co.  
(If outside city or town limits, write RURAL and give nearest town)Street No. West Hill Rd.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1947 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to Feb. 12, 1947and that I last saw him alive on February 12, 1947Immediate cause of death SenilityDue to Chronic Caducities

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Francis W. SmithAddress ChestertownDate signed 2/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

CENTRAL STATE OF DEATH

RECEIVED  
FEB 17 1947  
BUREAU V A

1-35



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01768  
Reg. Dist. No. 2001

### 1. PLACE OF DEATH:

County Kent  
City or town Rural Millington  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)  
State Kent County Kent  
City or town Rural Millington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Lavinia W. Simon

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife William Simon

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1891

8. AGE: Years 56 Months 3 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Phila. Pa.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Alexander MacGraw

13. Birthplace Phila. Pa.

14. Maiden name Margaret Eicher

15. Birthplace Phila. Pa.

16. Informant William Simon

Address Rural Millington Md.

17. Burial Date thereof Feb. 13, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Millington

Location Millington Md.

18. Funeral director Edward Fellows

Address Millington Md.

19. Feb. 12 1947 Edward Fellows  
(Date rec'd by registrar) (month) (day) (year) Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Feb 1947 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to 10 Feb 1947

and that I last saw him alive on 9 Feb 1947

Immediate cause of death Primary Carcinoma DURATION 12 mo.  
of Gall Bladder.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Primary Ca. of G. B. with extension into liver and pancreas. Date of op. 17 Nov 1946

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Richard W. Conway MD.

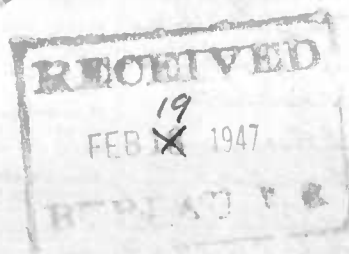
Address Clayton Del. Date signed 11 Feb 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01769

2020

## 1. PLACE OF DEATH:

County Kent  
 City or town near - Chestertown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 1 week  
 Hospital, institution, or street address where death occurred:  
R.F.D.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Caroline  
 City or town Denton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Catharine J. Stouffer3. (b) Social Security Number  
none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife William Stouffer 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept. 10, 1858  
 8. AGE: Years 88 Months 5 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation housewife  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name John Blackiston  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Nellie Unknown  
 15. Birthplace unknown

16. Informant Mrs. N. S. Lee (daughter)  
 Address Chestertown, Md.

17. Burial Date thereof Feb. 18, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Chester Cem.  
 Location Chestertown, Md.

18. Funeral director J. J. Willis Wells  
 Address Chestertown, Md.

19. Feb. 18, 1947 Class S. Barnes  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1947 at 11:30 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1947 to February 15, 1947  
 and that I last saw him alive on Feb. 15, 1947

Immediate cause of death \_\_\_\_\_ DURATION 1941  
Cardio Vascular  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank W. Smith M. D. or other \_\_\_\_\_  
Chestertown, R.R. Date signed 2/17/47

RECEIVED

FEB 20 1947

BUREAU V. E.

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

## 1. PLACE OF DEATH:

County Kent  
 City or town Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Kent  
 City or town Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
no  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William A. P. Strang

## 3. (b) Social Security Number

218-20-5260

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 8. AGE: Years 80 Months 0 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 6. (b) Name of husband or wife Estelle Biddle Strang  
living 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Jan. 29, 1867

9. Birthplace White Plains, New York  
 (Town, county, and state)  
 10. Usual occupation Teacher  
 11. Industry or business Public Schools  
 12. Name Unknown  
 13. Birthplace \_\_\_\_\_  
 14. Maiden name ? Browne  
 15. Birthplace unknown

16. Informant Mrs. Wm. A. P. Strang (wife)  
 Address Rock Hall, Md.  
 17. Burial Date thereof Feb. 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Chester Cemetery  
 Location Chestertown, Md.  
 18. Funeral director J. Willis Wells  
 Address Chestertown, Md.

19. Feb 7 19 47 S. Elwood Burgess  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 47 at 10:30 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 19 47 to Feb 4 19 47  
 and that I last saw him alive on Feb 4 19 47

Immediate cause of death Coma DURATION 1 Day

Due to Myocarditis 8 Days

Due to Arteriosclerosis 7

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. G. Simpkins M. D. or other

Address Chestertown Date signed Feb 7 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 10 1947

RECEIVED

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2030

Q1771

## 1. PLACE OF DEATH:

County..... Kent  
 City or town..... Piney Neck near Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Kent  
 City or town..... Near - Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Ella C. Ward

## 3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed  
 6.(b) Name of husband or wife..... John Ward  
 7. Birth date of deceased (mo., day, yr.)..... July 14, 1869 6.(c) If alive, give age..... years  
 8. AGE: Years..... 77 Months..... 7 Days..... 8 If less than one day..... hrs. .... min.

9. Birthplace..... Kent Co. Maryland  
(Town, county, and state)10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... Joseph Ashley  
 13. Birthplace..... Maryland

14. Maiden name..... Mary A. Grant  
 15. Birthplace..... Maryland

16. Informant..... Mr. Wilson Ward (son)  
 Address..... Rock Hall, Md.

17. Burial Date thereof..... Feb. 24, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Wesley Chapel Cem.  
 Location..... Rock Hall, Md.

18. Funeral director..... J. Willis Wells  
 Address..... Chestertown, Md.

19. 2/24 19 47 S. Howard Bingen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 22 19 47 at 7:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 19 45 to February 22 19 47  
 and that I last saw him alive on 2-21 19 47

## Immediate cause of death

chronic Endo-myocarditis  
chronic Bronchitis  
 Due to..... Bronchoecasis  
 Due to..... full bladder disease

## DURATION

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

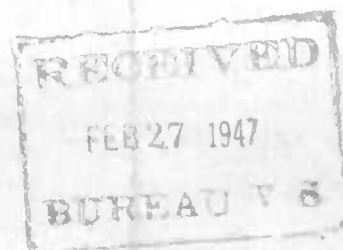
## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... Robert A. Burgard  
 M. D. or other.....  
 Address..... Rock Hall, Md. Date signed..... 2/23/47



1-55-

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

## CERTIFICATE OF DEATH

01772  
Reg. Dist. No. 202

### 1. PLACE OF DEATH:

County Kent  
City or town Chester town  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 days  
Hospital, institution, or street address where death occurred Kent and Green Cross Hospital  
How long in hospital or institution? 8 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent  
City or town Kennedysville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Robert C

### 3. (b) Social Security Number

Young

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White MARRIED

### B.(b) Name of husband or wife

MAY E. Young

7. Birth date of deceased (mo., day, yr.)

Oct. 21, 1860

B.(c) If alive, give age \_\_\_\_\_ years

### 8. AGE:

Years 86 Months 3 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### 9. Birthplace

Caroline Co., Md  
(Town, county, and state)

### 10. Usual occupation

Merchant

### 11. Industry or business

Merchant

### FATHER

12. Name John Young

### MOTHER

13. Birthplace Maryland

14. Maiden name Maria Reese

15. Birthplace Maryland

### 16. Informant

Hosp. records

### Address

Chester town, Md

### 17.

(Burial, cremation, or removal. Which?) Date thereof Feb. 18, 1947  
(month) (day) (year)

### Cemetery or crematory

Still Pond rd

### Location

Still Pond rd

### 18. Funeral director

J. B. Crello

### Address

Still Pond rd

### 19.

Feb. 18 19 47  
(Date rec'd by registrar)

Clara S. Barnes  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1947 at 7:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 19 47 to Feb. 15 19 47  
and that I last saw him alive on Feb. 15 19 47

### Immediate cause of death

Arteriosclerotic changes of left lower leg  
Due to Arteriosclerotic changes 10 years

### DURATION

### Due to

### Other conditions

(Include pregnancy within 3 months of death)

### Major findings of operations

### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

### Where did injury occur?

(City or town) (County) (State)

### Injured at home, farm, industry, public place (where?)

### Means of Injury

### Injured at work?

### 23. SIGNATURE

A. C. Dick M. D. or other

Address Chester town, Md Date signed 2-15-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

CERTIFICATE OF DEATH

STATE OF NEW YORK

RECEIVED

RECEIVED

FEB 20 1947

BUREAU T.E.

1-35